PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G161	A. BUILDING _____ B. WING _____	C 07/16/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRYSALLIS	3765 FIRST STREET, SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On July 3, 2008 at approximately 10:15 PM the State Agency (SA) was notified Direct Care Counselor (DCC) #1 witnessed DCC#2 hit Client #1 at a nightclub. An onsite investigation was initiated on July 10, 2008 to verify compliance with federal regulatory requirements in the condition of Governing Body and Client Protection. During the investigation, the SA determined that the behavior/actions of the facility's House Manager (HM) and the lack of the facility to take appropriate actions resulted in abuse/neglect which posed a serious and immediate threat to Client #1, Client #2, Client #3, Client #4, Client #5 and Client #6's health and safety. The Chief Executive Officer/President was notified of the immediate jeopardy concerns on July 14, 2008 at approximately 3:30 PM. [Note: SA surveyor remained at the facility until systems were in place to remove the immediate jeopardy. These systems included: terminating the House Manager immediately [July 14, 2008]; appointing the Qualified Mental Retardation Professional (QMRP) as temporary House Manager and hiring a new House Manager trained on incident reporting and abuse/neglect.	W 000		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review the facility failed toensure that systems were designed and implemented to ensure clients were not subjected to physical abuse (Cross refer to W127); failed to	W 122	In answer to W 122, the facility hereby cross-references and adopts the responses to W 127, W 149, W 155, W 156, and W 193 The Governing Body will more aggressively monitor the staff work performances and the operations of the facility to prevent a repeat of the concerns in W 122	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jean D. Wilson, President / CEO — TITLE — (X6) DATE: 8/15/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 122	Continued From page 1 implement policies that ensured each clients' health and safety; (Cross refer to W149) failed to protect clients from further potential abuse while an allegation of abuse was investigated; (Cross refer to W155); failed to report the results of all investigations to the administrator or designated representative or to other officials in accordance with State Law within five working days of the incident (Cross refer to W 156) and failed to demonstrate competency in implementation the Behavior Support Plan (BSP) for one of one client being investigated. (Client #1) (Cross refer to W193) The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety.	W 122		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems were designed and implemented to ensure clients were not subjected to physical abuse, for six of the six clients that resided in the facility. (Client #1, Client #2, Client #3, Client #4, Client #5 and Client #6) The findings include: Interview with DCC #1 on July 10, 2008 at approximately 4:35PM revealed that on July 3, 2008 at approximately 8:00 PM while at the	W 127	W 127 As answer to W 127, the facility says follows: 1. The behaviors and actions of the House Manager (HM) and DCC #2 in the incident of 7/03/08 involving client #1 are altogether very reprehensible and unconscionable. The HM and DCC # 2 chose to act contrary to all their experiences, trainings, policies and procedures of the facility. 2. The House Manager was consequently terminated and removed from the facility on 7/14/2008.A copy of the termination letter is hereby attached. Also the DCC #2 was terminated and permanently removed from the facility on 7/16/2008. A copy of the termination letter is hereby attached.	7/14/08 7/16/08

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W 127	Continued From page 2 nightclub, she witnessed Client #1 knock the eyeglasses off of DCC #2 and then witnessed DCC #2 used his opened hand to slap Client #1 across his face. DDC #1 immediately informed the House Manager (HM) of the incident. Interview with DCC #1 on July 14, 2008 at approximately 2:45 PM revealed that DCC #2 was allowed to ride back to the facility in the facility van with Client #1 and he remained on duty until the end of his shift at 12 midnight. Telephone interview with the Qualified Mental Retardation Professional (QMRP) on July 10, 2008 at approximately 5:30 PM revealed that on July 3, 2008 at 9:00 PM the HM informed him of the nightclub incident. He was informed by the HM that DCC #2 had turned in his resignation and had walked off the facility's property. The QMRP stated that he informed the HM that DCC #2's resignation would not stop the investigation and that he would notify the Chief Executive Officer (CEO) and other relevant parties. Telephone interview with the HM on July 11, 2008 at approximately 12:35 PM revealed conformed the details of the incident as reported by both DDC #1 and the QMRP. Further interview with the HM revealed that DCC #2 was terminated from employment on July 3, 2008. Telephone interview with the QMRP on July 11, 2008 at approximately 4:30 PM revealed that the Incident Management Coordinator (IMC) had informed him that DCC #2 had remained on duty until the end of his shift at 12midnight on July 3, 2008. Further interview revealed that DCC # 2 did not work in the facility after July 3, 2008 but that it	W 127	3. A new House Manager was appointed on 710/2008 effective 7/16/2008. A copy of the letter appointing a new HM is hereby attached. 4. The new HM is well trained and experienced in incident management and reporting. 5. Therefore there is no further threat of potential abuse to clients # 1, #2, #3, #4, #5, and #6 in the facility. 6. The QMRP will monitor supervise the new House manager to ensure quality services and performance.	7/16/08 Ongoing

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W 127	Continued From page 3 could not be confirmed when DCC #2 was placed on administrative leave. Interview with the IMC on July 14, 2008 at approximately 2:30 PM revealed that DCC #2 was placed on administrative leave on July 7, 2008 for physically abusing Client #1 by using his opened hand to slap Client #1 across his face. Further interview revealed that the QMRP was informed on July 12, 2008, that DCC #2 had remained on duty until the end of his shift at 12 midnight on July 3, 2008. Interview with DCC #2 on July 14, 2008 at approximately 3:00 PM revealed that Client #1 knocked his eyeglasses off at the nightclub. DCC #2 stated that he did not use his opened hand to slap Client #1 across his face but merely attempted to stop Client #1 from breaking his eyeglasses. DCC #2 stated that he rode back to the facility in the facility van and remained on duty until the end of his shift at 12 midnight. Further review revealed that DCC #2 was not informed by the HM on July 3, 2008 that he was to be placed on administrative leave pending the results of the investigation regarding the allegation of abuse. DCC #2 stated that he was scheduled to work on July 4-July 6, 2008, however he called in because he had family in town over the weekend. DCC #2 stated that he was verbally informed on July 7, 2008, by the IMC that he was on administrative leave pending the results of the investigation regarding the allegation of abuse. Interview with HM #2 from another facility on July 15, 2008 at approximately 5:00PM revealed that on July 3, 2008 at approximately 8:00 PM while at the nightclub, also witnessed the incident described by DDC #1. HM#2 immediately	W 127		

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W 127	Continued From page 4 informed the nightclub's security guard of the witnessed physical abuse. HM#2 also witnessed DCC #2 escoting Client #1 out of the nightclub into the facility's van after the incident. The SA determined that the the House Manager was made aware that Client #1 was physically abused by DCC# 2 and did not protect Client #1 from further potential harm. The HM allowed DCC #2 to remain on duty to provide one to one supervision to Client #1. The SA determined that the behavior/actions of the facility's House Manager (HM) resulted in abuse/neglect which posed a serious and immediate threat to Client #1, Client #2, Client #3, Client #4, Client #5 and Client #6's health and safety. The Chief Executive Officer/President was notified of the immediate jeopardy concerns on July 14, 2008 at approximately 3:30 PM. [Note: The State Agency surveyor remained until the facility put systems in place to remove the immediate jeopardy by terminating the House Manager immediately, appointing the Qualified Mental Retardation Professional (QMRP) as temporary House Manager and hiring a new House Manager trained on incident reporting and abuse/neglect effective July 16, 2008.]	W 127	W 149 As answer to W 149, the facility says follows: 1. The facility developed and has been implementing its incident management policy and procedures, but on 7/03/2008, the House Manager recklessly derailed the facility's incident management policies and procedures. The said House Manager's employment has been terminated. A new House Manager has been appointed and will continue to implement the facility's incident management policies and procedures. 2. As further response to W 149, the facility hereby cross references the answers to W 127 and adopts same hereto.	Ongoing 7/14/08 7/16/08
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the	W 149		

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W 149	Continued From page 5 facility's House Manager (HM) failed to implement it's incident management protocol for one of one client in the investigation (Client #1). The finding includes: Interview and record review on July 14, 2008 at approximately 3:20 PM revealed that the House Manager did not follow the facility's incident management policy that required that any employee alleged to have committed any form of abuse or neglect be removed from duty. The HM allowed Direct Care Counselor (DCC) #2 to remain on duty to provide one to one supervision to Client #1. There was no evidence that the facility's House Manager implemented it's incident management policy.	W 149		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that Client #1 was protected from further potential abuse while an allegation of abuse was investigated. The finding includes: Cross refer to W127. Interview with Direct Care Counselor #2 on July 14, 2008 at approximately 3:00 PM revealed that he rode back to the facility in the facility van with Client #1 and remained on duty until the end of his shift at 12 midnight.	W 155	W 155 As answer to 155, the facility says as follows: 1. The facility's House Manager failed to remove the Direct Care Counselor # 2 from duty immediately as required by the facility's policies and procedures on 7/03/2008. The HM also misrepresented the facts to his supervisors for reasons that incomprehensible. However, the HM's employment with facility has been terminated. He has been removed from the facility, and a new House Manager has been appointed.	7/14/08 7/16/08

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W 155	Continued From page 6 Further review revealed that DCC #2 was not informed by the HM on July 3, 2008 that he was to be placed on administrative leave pending the results of the investigation regarding the allegation of abuse. DCC #2 stated that he was scheduled to work on July 4-July 6, 2008, however he called in because he had family in town over the weekend. DCC #2 stated that he was verbally informed on July 7, 2008, by the Incident Management Coordinator (IMC) that he was on administrative leave pending the results of the investigation regarding the allegation of abuse. Interview with HM #1 on July 14, 2008 at approximately 3:20 PM revealed that he allowed DCC #2 to remain on duty to provide one to one supervision to Client #1 after the incident. Interview with HM#2 on July 15, 2008 at approximately 5:00 PM revealed that she also witnessed DCC #2 escot Client #1 out of the nightclub into the facility's van after the incident. There was no evidence that the facility's House Manager protected Client #1 from further potential abuse while an allegation of abuse was investigated.	W 155	W 156 As response to W 156, the facility says as follows: 1. The incident that was investigated took place in public club that opens only on certain days. The internal investigation could not be completed because of lack of access to a critical witness. The investigator had to wait until a certain day when the club opens to provide services. The evidence of HM # 2 was critical to determination of the case and this evidence was obtained when the club opened and this placed the investigation outside the time limit. 2. The administrator of the facility was informed about the critical witness access problem and the need to extend the time to secure the evidence of HM # 2. 2. However, the facility will endeavor to limit investigation to five days as stipulated in the policy	ongoing
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review the facility	W 156		

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W 156	Continued From page 7 failed to report the results of all investigations to the administrator or designated representative or to other officials in accordance with State Law within five working days of the incident. The finding includes: Review of the internal investigative report on July 18, 2008 at approximately 1:31 PM revealed that the incident occured on July 3, 2008 and internal investigation was completed on July 16, 2008. Further review revealed that the Administrator signed the internal investigation on July 16, 2008. There was no evidence the result of the investigation was reported to the administrator within five working days of the incident.	W 156	W 189 As answer to W 189, the facility says as follows: 1. The House manager received effective training on incident management policy and procedures as well as other training requirements. The House Manager malfunctioned and failed to implement the policies and procedures as required. He acted contrary to his experience, training and knowledge. His employment was terminated on 7/14/08 2. The Direct Care Counselor to client # 1 received effective training on client # 1 Behavior Support Plan and Incident management policy and procedures as well as other training requirements. The said direct care staff malfunctioned and recklessly failed to implement client # 1 BSP and policies and procedures as required. He acted contrary to his experience, training and knowledge. His employment was terminated on 7/16/08	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: 1. Cross Refer to W127. The facility failed to ensure that the House Manager had received effective training on their incident management policy ensuring that clients were not subjected to physical abuse while an allegation of abuse was	W 189		7/14/08 7/16/08

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W 189	Continued From page 8 investigated. 2. Cross Refer to W193. The facility staff failed to ensure that Direct Care Counselors received effective training to demonstrate competency in implementing the Behavior Support Plan (BSP) for Client #1.	W 189		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on staff interviews and record verification, the facility staff failed to demonstrate competency in implementation the Behavior Support Plan (BSP) for one of one client being investigated. (Client #1) The finding includes: Review if an unusual incident report dated July 3, 2008, on July 9, 2008 at approximately 6:00 PM revealed that Direct Care Counselor (DDC) #1 witnessed DDC #2, smack Client #1 at the nightclub. a. Interview with DDC #1 on July 10, 2008 at approximately 4:35PM revealed that on July 3, 2008 at approximately 8:00 PM while at the nightclub, she witnessed Client #1 knock DDC #2's eyeglasses off and that DDC #2 than used his opened hand to slap Client #1 across his face. b. Interview with DDC #2 on July 14, 2008 at approximately 3:00 PM revealed that on July 3, 2008 at approximately 8:00 PM, Client #1	W 193	W 193 As answer to w 193, the facility says as follows: 1. The Direct Care Counselor to client # 1 received effective training on client # 1 Behavior Support Plan and Incident management policy and procedures as well as other training requirements. 2. The said direct care staff malfunctioned and recklessly failed to demonstrate competency and skills in implementing client # 1 BSP and policies and procedures as required. 3. He acted contrary to his experience, training and knowledge. His employment was terminated on 7/16/08	6/4/8 Ongoing

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W 193	Continued From page 9 knocked his eyeglasses off at the nightclub. DDC #2 stated that he did not use his opened hand to slap Client #1 across his face but merely attempted to stop Client #1 from breaking his eyeglasses by pushing Client #1 away. c. Interview with other staff witnesses during this investigation revealed that on July 3, 2008 at approximately 8:00 PM while at the nightclub, Client #1 knocked DDC #2's eyeglasses off and DDC #2 then used his opened hand to slap Client #1 across his face. Review of Client #1's Behavioral Support Plan (BSP) dated November 17, 2007 on July 10, 2008 at approximately 6:00 PM revealed targeted behaviors that included physical aggression, hitting, scratching, grabbing, pulling and throwing objects at others; clients and staff and across the room. Further review revealed that interventions for physical aggression included "saying stop, one to one to re-direct the client to another area and provide neutral physical/verbal contact to reduce possible reinforcement." There was no evidence that on July 3, 2008, the facility staff demonstrated competency in the implementation of the client's BSP.	W 193		

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I 000	INITIAL COMMENTS On July 3, 2008 at approximately 10:15 PM the State Agency (SA) was notified Direct Care Counselor (DCC) #1 witnessed DCC#2 hit Resident #1 at a nightclub. An onsite investigation was initiated on July 10, 2008 to verify compliance with federal regulatory requirements in the condition of Governing Body and Client Protection. During the investigation, the SA determined that the behavior/actions of the facility's House Manager (HM) and the lack of the facility to take appropriate actions resulted in abuse/neglect which posed a serious and immediate threat to Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 and Resident #6's health and safety. The Chief Executive Officer/President was notified of the immediate jeopardy concerns on July 14, 2008 at approximately 3:30 PM. [Note: SA surveyor remained at the facility until systems were in place to remove the immediate jeopardy. These systems included: terminating the House Manager immediately [July 14, 2008]; appointing the Qualified Mental Retardation Professional (QMRP) as temporary House Manager and hiring a new House Manager trained on incident reporting and abuse/neglect.	I 000		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Each GHMRP residence director shall ensure	I 500		

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I 500	Continued From page 1 that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. The finding includes: Interview with DCC #1 on July 10, 2008 at approximately 4:35PM revealed that on July 3, 2008 at approximately 8:00 PM while at the nightclub, she witnessed Resident #1 knock the eyeglasses off of DCC #2 and then witnessed DCC #2 used his opened hand to slap Resident #1 across his face. DDC #1 immediately informed the House Manager (HM) of the incident. Interview with DCC #1 on July 14, 2008 at approximately 2:45 PM revealed that DCC #2 was allowed to ride back to the facility in the facility van with Resident #1 and he remained on duty until the end of his shift at 12 midnight. Telephone interview with the Qualified Mental Retardation Professional (QMRP) on July 10, 2008 at approximately 5:30 PM revealed that on July 3, 2008 at 9:00 PM the HM informed him of the nightclub incident. He was informed by the HM that DCC #2 had turned in his resignation and had walked off the facility's property. The QMRP stated that he informed the HM that DCC #2's resignation would not stop the investigation and that he would notify the Chief Executive Officer (CEO) and other relevant parties. Telephone interview with the HM on July 11, 2008 at approximately 12:35 PM revealed conformed the details of the incident as reported by both DDC #1 and the QMRP. Further interview with the HM revealed that DCC #2 was terminated from employment on July 3,	I 500	TAG 1500 As answer to 1500, the facility says as follows: 1. The behaviors and actions of the House Manager (HM) and DCC #2 in the incident of 7/03/08 involving client #1 are altogether very reprehensible and unconscionable. The HM and DCC # 2 chose to act contrary to all their experiences, trainings, policies and procedures of the facility. 2. The House Manager was consequently terminated and removed from the facility on 7/14/2008.A copy of the termination letter is hereby attached. Also the DCC #2 was terminated and permanently removed from the facility on 7/16/2008. A copy of the termination letter is hereby attached.	7/14/08 7/16/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0229	A. BUILDING _____ B. WING _____	C 07/16/2008

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I 500	Continued From page 2 2008. Telephone interview with the QMRP on July 11, 2008 at approximately 4:30 PM revealed that the Incident Management Coordinator (IMC) had informed him that DCC #2 had remained on duty until the end of his shift at 12midnight on July 3, 2008. Further interview revealed that DCC # 2 did not work in the facility after July 3, 2008 but that it could not be confirmed when DCC #2 was placed on administrative leave. Interview with the IMC on July 14, 2008 at approximately 2:30 PM revealed that DCC #2 was placed on administrative leave on July 7, 2008 for physically abusing Resident #1 by using his opened hand to slap Resident #1 across his face. Further interview revealed that the QMRP was informed on July 12, 2008, that DCC #2 had remained on duty until the end of his shift at 12 midnight on July 3, 2008. Interview with DCC #2 on July 14, 2008 at approximately 3:00 PM revealed that Resident #1 knocked his eyeglasses off at the nightclub. DCC #2 stated that he did not use his opened hand to slap Client #1 across his face but merely attempted to stop Resident #1 from breaking his eyeglasses. DCC #2 stated that he rode back to the facility in the facility van and remained on duty until the end of his shift at 12 midnight. Further review revealed that DCC #2 was not informed by the HM on July 3, 2008 that he was to be placed on administrative leave pending the results of the investigation regarding the allegation of abuse. DCC #2 stated that he was scheduled to work on July 4-July 6, 2008, however he called in because he had family in town over the weekend. DCC #2 stated that he was verbally informed on July 7, 2008, by the IMC that he was on administrative	I 500	3. A new House Manager was appointed on 710/2008 effective 7/16/2008. A copy of the letter appointing a new HM is hereby attached. 4. The new HM is well trained and experienced in incident management and reporting. 5. Therefore there is no further threat of potential abuse to clients # 1, #2, #3, #4, #5, and #6 in the facility. 6. The QMRP will monitor supervise the new House manager to ensure quality services and performance. Furthermore, to ensure that the rights of the clients of the facility are observed and protected as required by law.	7/16/08 ongoing ongoing

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I 500	Continued From page 3 leave pending the results of the investigation regarding the allegation of abuse. Interview with HM#2 from another facility on July 15, 2008 at approximately 5:00PM revealed that on July 3, 2008 at approximately 8:00 PM while at the nightclub, also witnessed the incident described by DDC #1. HM #2 immediately informed the nightclub's security guard of the witnessed physical abuse. HM #2 also witnessed DCC #2 escoting Resident #1 out of the nightclub into the facility's van after the incident. The SA determined that the the HM was made aware that Resident #1 was physically abused by DCC# 2 and did not protect Resident #1 from further potential harm. The HM allowed DCC #2 to remain on duty to provide one to one supervision to Resident #1. The SA determined that the behavior/actions of the facility's House Manager (HM) resulted in abuse/neglect which posed a serious and immediate threat to Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 and Resident #6's health and safety. The Chief Executive Officer/President was notified of the immediate jeopardy concerns on July 14, 2008 at approximately 3:30 PM. [Note: The State Agency surveyor remained until the facility put systems in place to remove the immediate jeopardy by terminating the House Manager immediately, appointing the Qualified Mental Retardation Professional (QMRP) as temporary House Manager and hiring a new House Manager trained on incident reporting and abuse/neglect effective July 16, 2008.]	I 500		